

Close Contact Exposure Declaration Form

Please complete this form to declare any close contact exposure to a confirmed or suspected case of infectious disease. This information is collected for safety, screening, and contact tracing purposes.

1. Declarant Information

Full Name:

Phone Number:

Email Address:

Department / Company / Organization:

2. Exposure Details

Date of Last Close Contact (YYYY-MM-DD):

Name of the Confirmed/Suspected Case (if known):

Relationship to the Confirmed/Suspected Case (e.g., family, co-worker, friend):

Location/Setting where the exposure occurred:

3. Health and Symptom Status

Are you currently experiencing any symptoms? (Type YES or NO):

If YES, please list your symptoms (e.g., fever, cough, shortness of breath, sore throat):

Have you taken a diagnostic test since the exposure? (Type YES or NO):

If YES, what was the test result? (Type Positive, Negative, or Pending):

4. Declaration and Signature

I hereby declare that the information provided in this form is true, complete, and accurate to the best of my knowledge.

Printed Name of Declarant:

Physical Signature (Sign here after printing):

Date of Declaration (YYYY-MM-DD):